ASC Newsletter

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Indiana State Department of Health

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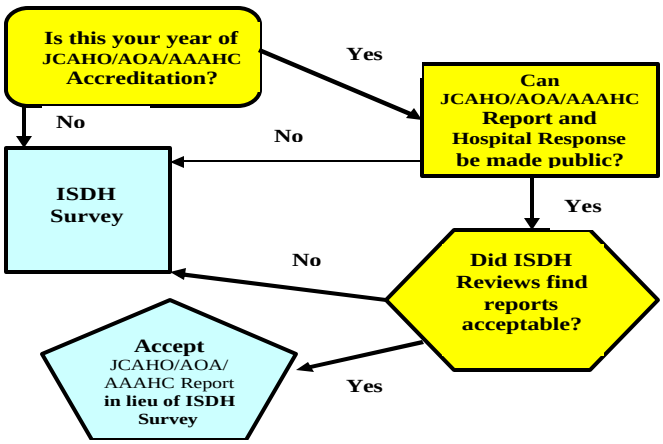
Deemed Status In Lieu of ISDH Surveys

In January 2004, the Acute Care Division will implement a new survey process in surgical centers licensed in Indiana by the ISDH. The new survey process will include recognition of the "CMS deemed accreditation" of the JCAHO, AAAHC, or AOA accreditation surveys.

ISDH will accept a JCAHO, AAAHC, and AOA "deemed accreditation survey" for the same calendar year in lieu of a survey when ISDH staff has found that the accreditation survey and the ASC response is equivalent to ISDH compliance to rules.

We are seeking your cooperation in this new approach.



X-Ray Technologist License Renewal

Physicians and physicists are reminded to periodically review the posted ISDH licenses of x-ray technologists are reviewed - to ensure that these individuals renew their license every two years.

The ISDH Indoor and Radiological Health Division is finding that some of the 13,000 technologists are not responding to ISDH reminders to file a renewal. Hospitals and surgical centers then find that technologist's license is expired, and the supervising physician is then responsible to take the x-ray until a technologist is in good standing.

The ISDH Indoor and Radiological Health Division will send a reminder to each technologist three months prior to expiration requesting that they renew their license with a $60 renewal application. Technologists failing to file a renewal application on time must pay an additional $60 late fee.

Additional information on these requirements can be obtained by contacting Mr. John Ruyack at 317/233-7146. ASCs will be cited under state and federal regulations, if the technologists are found to be without a current license.

Inside this issue:

'Indiana Cancer Facts & Figures'

The Indiana Cancer Consortium has published Indiana's first comprehensive report on cancer--"Indiana Cancer Facts and Figures."

This 32-page report contains the most accurate and current cancer data for Indiana ever assembled in a single source.

"Indiana Cancer Facts and Figures" shows that cancer incidence rates in Indiana, in general, are below U.S. rates, while cancer mortality rates are generally higher. Dr. Greg Wilson, State Health Commissioner, says this demonstrates the clear need for increased cancer screening and earlier detection of cancer.

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The data show, for instance, that only 38 percent of colorectal cancer cases in Indiana are diagnosed in local stages or earlier, compared to the national average of 37 percent. Only 45 percent of Indiana residents over age 50 report ever having had a sigmoidoscopy or colonoscopy, even though colon and rectal cancers are more than 90 percent survivable when detected early through screening. colonoscopy. Nationally, 48.1 percent of people over age 50 report ever having had a sigmoidoscopy or colonoscopy.

"Indiana Cancer Facts and Figures" is available to the public on the American Cancer Society Web site, www.cancer.org/Indianafacts

Florida Study on Adverse Events

In the September 2003 *Archives of Surgery*, researchers found that there were a rate of 5.3 adverse events per 100,000 procedures in outpatient surgical centers, compared to a rate of 66 per 100,000 procedures in physicians’ offices.

This was based on a Florida statistical study of reported incidence reports over a one-year period from 2001 to 2002. (Source: http://archsurg.ama-assn.org/cgi/content/abstract/138/9/991)

Data Update

Based on suggestions from several surgical outcome questionnaires, ISDH is changing its definition of procedures. The new definition of procedure is **(1) performed for diagnostic, definitive, or exploratory purpose and/or necessary to take care of a complication, (2) surgical in nature, carries a procedural or anesthetic risk or requires specialized training, and (3) a billable procedure identified in the AMA CPT Manual.**

Please review page 3 of the instructions for implementing these changes starting with fourth quarter 2003 reporting.

Wrong Surgical Site Protocol

Enclosed within this mailing is the Universal Protocol for preventing wrong site, wrong procedure, and wrong person surgery. The principal components of the Universal Protocol include (1) the preoperative verification process; (2) marking of operate site; (3) taking a "time out” immediately before starting the procedure; and (4) adaptation of the requirements to non-operating room settings, including beside procedures.

Most of professional associations adopted this protocol last spring and recommended that the protocol should be in use for JCAHO accreditation beginning on July 1, 2004.

(Source: See page 3)

Guidelines for Implementing the Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery

These guide lines provide detailed implementation requirements, exemptions and adaptations for special situations.

- **Pre-operative verification process**

Verification of the correct person, procedure, and site should occur (as applicable):

- At the time the surgery/procedure is scheduled.
- At the time of admission or entry into the facility.
- Anytime the responsibility for care of the patient is transferred to another caregiver.
- With the patient involved, awake and aware, if possible.
- Before the patient leaves the preoperative area or enters the procedure/surgery room.

A preoperative verification checklist may be helpful to ensure availability and review of the following prior to the start of the procedure:

- Relevant documentation (e.g., H&P, consent).
- Relevant images, property labeled and displayed.
- Any required implants and special equipment.

- **Making the operative site**
- Make the mark at or near the incision site. Do NOT mark any non-operative site (s) unless necessary for some other aspect of care.
- The mark should be unambiguous (e.g., use initials or "YES" or a line representing the proposed incision; that "X" may be ambiguous).
- The mark should be positioned to be visible after the patient is prepped and draped.
- The mark should be made using a marker that is sufficiently permanent to remain visible after completion of the skin prep. Adhesive site markers should not be used as the sole means of making the site.
- The method of making any type of mark should be consistent throughout the organization.
- At a minimum, mark all cases involving laterality, multiple structure (fingers, toes, lesions), or multiple levels (spine). Note: In addition to preoperative skin marking of the general spinal region special intraoperative radiographic technique are used for marking the exact vertebral level).
- The person performing the procedure should do the site marking.
- Marking should take place with the patient involved, awake, and aware, if possible.
- Final verification of the site mark should take place during the "time out."
- A defined procedure should be in place for patient who refuse site marking.

- **Exemptions:**
- Single organ cases (e.g., Cesarean section, cardiac surgery).
- Interventional cases for which the catheter/instrument insertion site is not predetermined (e.g., cardiac catheterization).
- Teeth-BUT, indicate operative tooth name (s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram.
- Premature infants, for whom the mark may cause a permanent tattoo.

- **"Time out" immediately before starting the procedure.**

Should be conducted in the location where the procedure will be done, just before starting the procedure. It should involve the entire operative team, use active communication, be briefly documented, such as in a checklist (the organization should determine the type and amount of documentation) and should include:

- Correct patient identity.
- Correct side and site.
- Agreement on the procedure to be done.
- Correct patient position.
- Availability of correct implants and any special equipment or special requirements.

The organization should have processes and systems in place for reconciling differences in staff responses during the "time out."

- **Procedures for non-OR setting including bedsides procedures.**
- Site marking should be done for any procedure that involves laterality, multiple structure or levels (even if the procedure takes place outside of and OR).
- Verification, site marking and "time out" procedures should be as consistent as possible throughout the organization, including the OR and other locations where invasive procedures are done.
- Exception: Cases in which the individual doing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and consent from the patient through to the conduct of the procedure may be exempted from the site marking requirement. The requirement for a "time out' final verification still applies.

New ISDH Assistant Commissioner

On September 2, 2003, Terry Whitson became the assistant commissioner for the Health Care Regulatory Services Commission. Whitson takes over from Liz Carroll who was named the Deputy State Health Commissioner.

Whitson joined the ISDH in February 1999 as a staff attorney and has served as supervising attorney since September 2001. As the new assistant commissioner, Whitson will oversee the acute care, consumer protection, and long-term care divisions. Prior to coming to the ISDH, Whitson was Associate Professor and Program Director of Radiological Sciences at Marian College and was previously was on the faculty of the Indiana University School of Medicine.

Whitson's educational background includes undergraduate degrees in radiological technology, a master's degree in health education, and a law degree. Whitson has been admitted to candidacy and is currently completing a Ph.D. in higher education administration. All of his degrees are from Indiana University.

CA Reporting Delayed for Cancer Registry

The Indiana State Cancer Registry is requesting all ASC's to not submit any cancer cases diagnosed 1-1-03 or later until notified. This delay is necessary because ISDH software is not able to process the case information. The delay will allow ISDH staff to update its software to reflect new national coding guidelines.

This applies to only electronic submissions. Organizations sending paper copies of records to the State Registry are not affected by these changes, and should continue to send cases in the same manner as before.

Proposed Change in ISDH ASC Rule

Based on a discussion by a provider advisory committee, ISDH is proposing the addition of licensure fees for ambulatory outpatient surgical centers. The proposed rule would set a sliding scale of fees - based on the number of annual procedures of the center. The licensure fee, if approved, will be used as dedicated fund to retain and attract qualified ISDH survey staff.

It is expected that the ISDH will announce its intent to publish the rule in November 2003, and request the Indiana Hospital Council to begin the rule development process. After November 1, 2003, the intent to publish rule will be at http://www.in.gov/legislative/register/index-26.html

Telephone Directory by Topic

ASC Program & Procedure Changes
Ann Hamel
317.233.7487

Plan Review
Wes Anderson
317.233.7882

Data Reporting
Tom Reed
317.233.7541

We're on the Web!
www.statehealth.in.gov

ASC Information on ISDH Web Site

- Directory (with quarterly updates)
- Laws/Rules/Regulations (USA & IN)
- ASC Licensing Form
- Surgical Report
- Links to QA organizations

www.IN.gov/isdh/regsvcs/providers.htm

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